

Elizabeth Mikulik, MA, LPC, ACS

52 Reckless Place 46 North Central Ave.
Red Bank, NJ 07701 Ramsey, NJ 07446
(732) 228-0533 (201) 264-4011
Fax: 866-909-6386

NPI Number: 1861724121

License Number: 37PC003955700

Client Information

Name: _____ Date of Birth: _____

Mailing Address: _____

City/Town: _____ State: _____ Zip Code: _____

Physical address if Different from Mailing: _____

Home Phone: _____ Cell Phone: _____

Is it alright to text you regarding appointments? _____

Whom may I thank for referring you? _____ Phone: _____

In Case of Emergency whom may I contact? _____ Phone: _____

Parent/Guardian Information

Name: _____ Date of Birth: _____

Mailing Address: _____

City/Town: _____ State: _____ Zip Code: _____

Physical address if Different from Mailing: _____

Home Phone: _____ Cell Phone: _____

Is it alright to text you regarding appointments? _____

Consent for the Assessment and/or Treatment of a Minor

In the instance of the treatment of a minor. I, _____, do hereby authorize that
Parent/Guardian
_____ may receive psychological/counseling treatment and/or evaluation provided by
Child
Elizabeth Mikulik, MA, LPC, LLC. I am aware that all custodial parents and guardians must give consent
before treatment begins. A copy of written custody agreements if applicable will be delivered to this address
prior to the first assessment with the child/minor.

Signature of parent/guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

Signature of parent/guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (“Notice”) applies to Protected Health Information (defined below) associated with Group Health Plans (defined below) provided by Elizabeth Mikulik, MA, LPC, LLC. to its employees, its employee’s dependents and, as applicable, retired employees. This Notice describes how Elizabeth Mikulik, MA, LPC, LLC, collectively we, may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) to maintain the privacy of Protected Health Information and to provide individuals covered under our group health plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders then covered by the Group Health Plan. Copies of our current Notice may be obtained by contacting Elizabeth Mikulik, MA, LPC, LLC. at the telephone number or address below, or on our Facebook address.

DEFINITIONS

Group Health Plan means, for purposes of this Notice, the following employee benefits that we provide to our employees, employee dependents and, as applicable, retired employees, as well as providing a bill for a patient to submit on their own for out of network benefits.

Protected Health Information (“PHI”) means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is

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a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining coverage under the group health plan, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Uses and Disclosures for Payment – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan.

Uses and Disclosures for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your Group Health Plan coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Group Health Plan.

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide you with the benefits of your Group Health Plan. Examples of these outside persons and organizations might include vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Group

Health Plan coverage, and about health-related products and services that may add value to your Group Health Plan.

Other Uses and Disclosures – We may make certain other uses and disclosures of your PHI without your authorization.

- We may use or disclose your PHI for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as described above, we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard.

RIGHTS THAT YOU HAVE

Access to Your PHI – You have the right of access to copy and/or inspect your PHI that we maintain in designated record sets. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). Access request forms are available from Elizabeth Mikulik, MA, LPC, LLC at the address below. We may charge you a fee for copying and postage.

Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful

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consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request. Amendment request forms are available from us at the address below.

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from us at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your PHI – You have the right to request restrictions on certain of our uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. We are not required to agree to your request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voicemail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact Elizabeth Mikulik, MA, LPC, LLC, directly.

EFFECTIVE DATE

This Notice is effective April 7, 2017.

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Service Agreement

Confidentiality

All professional contacts with me are safeguarded by confidentiality regulations. However, there are exceptions to confidentiality which include, but are not limited to the following:

- Instances involving abuse to a child, elderly, or disabled person
- Situations in which the client is judged to be threatening serious harm to him or herself or another person
- Judicial proceedings involving a court order to testify
- When collecting agencies or other processes are required to collect unpaid fees

If you are involved in a legal case in which your mental status is at issue and the services you have requested are NOT for expert opinion or testimony then please be advised that your therapist, in order to avoid a conflict of interest and to preserve the therapist-patient relationship, cannot serve as an independent expert at a later date. If you are in need of an expert opinion or evaluation, please make that known to the therapist BEFORE the start of services. If you have any questions regarding these circumstances, you are encouraged to ask the therapist.

Sessions

Individual, family, group and couples therapy sessions are usually scheduled on a weekly basis, unless otherwise indicated. The therapist(s) will make an effort to begin your session and/or group in a timely fashion, and would likewise appreciate your timeliness in keeping appointments. You are free to terminate therapy at any time. Termination is usually a mutual plan that is planned for the patient and therapist together. If at any time you feel that therapy is not meeting your needs, you are strongly encouraged to present your concerns to the therapist.

If you participate in or are interested in participating in a group therapy session an assessment for appropriateness will be conducted prior to acceptance in any group psychotherapy that is offered. This assessment will be provided at the assessment rate of the therapist, which is conducting the assessment.

If you participate in group, family, or couples therapy it is suggested that you do not discuss the contents of those sessions with any other person who is not a fellow patient undergoing treatment with you in the same counseling sessions. Also, you must agree not to hold the therapist responsible for any group/family/couples therapy member's behavior. In the case of minors, it is important that parents/guardians understand the need of

their children to develop trust in their therapists. Thus, the therapist asks the parents/guardians limit their desire for specific details of the treatment. However, the therapist will be sure to address any concerns that parents may have regarding their child's treatment.

Please be aware that the therapist is not liable for any patient once an individual or group session has ended. This is not limited to the supervision of any patient or client following the cessation of any group therapy session. Group therapy sessions are held back to back, and each therapist running the groups must be present in all preceding groups and will therefore be unable to provide supervision from the time group therapy ends to the time a family member arrives to pick up a patient. It is the parent's responsibility to be present at the end of the group/ individual session in order to provide supervision and transportation home in a timely manner, to their child or ward.

If you have come to treatment for psychotherapy, please be aware that this process is often exciting and involves significant change. At times, it may also seem frustrating and may arouse strong, difficult emotions. You may discover that the way you think about the world, the way you view your past, present, and future, and the way you relate to others may be altered. Therapy will require your work and commitment. The most important mission as a therapist is to help you to make progress in your work towards reaching your goals. The therapist will strive at all times to utilize the best clinical skills and professional judgment in this endeavor.

Cancellations and Missed Appointments

If you are unable to keep a scheduled appointment, 24 hour notice is required for cancellation. Late notification or failure to attend a scheduled appointment will be billed. In the case of a bona fide emergency, the fee will be waived. Group therapy sessions are paid at cessation of each session by each client. If another payment arrangement is required it must be agreed upon prior to the client beginning in either group, couples, family, or individual treatment.

Billing and Payments

Payment is due in full at the time service is rendered unless other arrangements have been made. There is a returned check fee. All group sessions are paid in full at the beginning of the treatment increment.

Insurance/Healthcare

The therapist is not responsible for insurance or healthcare coverage. It is strongly recommended that you clarify the extent of any coverage from your carrier. Please be advised that what your insurance representative/provider says over the phone to you may not always be correct or clear. Ultimately, you are responsible for the payment of the services rendered to you-that is, if for any reason the insurance company denies payment for services, you will be responsible for the payment. Group and individual therapists in this treatment phase may not be involved in health insurance networks. In this instance a receipt for payment will be provided and you are welcome to submit this receipt for your out of network benefit, unless other arrangements are otherwise agreed upon prior to the initial assessment. Please be aware of what your out of network benefit is. If you would like our therapist to look into this for you, she may request the completion of a healthcare claim form and/or verification form which will request confidential information for that verification.

Emergencies

The therapist is available by telephone at times other than your scheduled appointment, if there is a matter that cannot wait until the next session. For any telephone calls which last fifteen minutes or longer, the therapist reserves the right to charge you a fee proportional to the individual psychotherapy rate. If you have an emergency and call after business hours or cannot reach your therapist, call the emergency room at Jersey Shore Medical Center, or Monmouth Medical Center, or your local hospital emergency room **immediately**.

After you have read this form, please sign your name and the date below indicating that you have understood and accepted what you have read. Thank you.

Signature of Patient if age 14 or over

Date

Signature of Parent/Guardian

Date